American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Illinois Chapter

December 3, 2010

TO: Illinois Health Care Reform Implementation Council

FR: Illinois Chapter, American Academy of Pediatrics (ICAAP)

RE: Functions of a Health Benefit Exchange (HBE)

On behalf of the Illinois Chapter of the American Academy of Pediatrics and its 2,000 members statewide, we offer the following comments to the Illinois Health Care Reform Implementation Council established by Governor Quinn. We hope these comments are useful in establishing a Health Benefit Exchange (HBE) for Illinois and are available to continue to serve as a resource to the Council, the Governor and relevant state agencies as we move forward.

We have tried to provide comments in relation to the questions posed in the "Key Issues for Public Comment" when possible and when we had relevant input.

Functions of a Health Benefit Exchange (HBE)

What advantages will Illinois see in operating its own exchange versus permitting the U.S. Department of Health and Human Services (HHS) to run an Exchange for the State?

The Illinois HBE should be run locally with strong links to the Illinois Department of Insurance, the Illinois Department of Healthcare and Family Services (IDHFS), and other agencies regardless of specific location. By operating its own HBE, Illinois will see many benefits that may not be possible with a federally-run Exchange.

Our goal, in order meet the best interests of Illinois consumers, should be to streamline as much information delivery and enrollment processing as possible. This will entail incorporating benefit information about subsidized health insurance, including state Medicaid and SCHIP programs, as mandated, but also incorporating information on Illinois-specific human and social service programs. There is a better chance that Illinois will be able to streamline enrollments and use data from participation in multiple programs to direct benefits to consumers if the program is run locally. As much as possible, linkages with other public programs should be automatic.

In addition, Illinois will be able to create synergy with IDHFS and its programs. IDHFS has shown significant progress in consumer and provider outreach regarding All Kids and its various plans; a local HBE will not only benefit from the system and outreach strategies already in place, but will bring additional resources to that outreach, if structured appropriately, that can help streamline enrollment processes and transitions between plans internally within the state most efficiently.

Finally, it is our belief that consumers, advocates and providers will be more confident in something run locally, and will feel more empowered to identify barriers and advocate for positive changes when the program is run by state agency staff we already work closely with.

What, if any, Exchange functions beyond the minimum clearinghouse functions required in the ACA would benefit Illinois and why? What advantages are presented to Illinois if the Exchange were to limit the number of plans offered; for example, plans could be required to compete on attributes such as price or quality rating? Is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

ICAAP supports further exploration of many of the functions considered "optional" by the ACA and believes that implementing those that are feasible will improve health care in Illinois by increasing transparency, improving consumers' ability to make informed choices, and strengthening a statewide commitment to quality. All Illinois citizens, but particularly vulnerable groups such as developing children and families-at-risk, need access to the highest quality health plans that offer solid coverage and accessible services. Illinois should vet health plans entering into the Exchange to ensure high quality. Furthermore, Illinois should negotiate with insurers over premiums to make certain that policies are affordable, and should negotiate with insurers over benefit packages to make sure that critical services are covered. Historically, areas of concern regarding pediatric services that may be lacking in benefit packages include *comprehensive* oral/dental health services, mental health services including specifically pediatric mental health care, full coverage of all recommended immunizations, pediatric specialty care services, coverage of diagnosis services and therapies/treatments for certain disabilities such as autism, and access to all recommended screenings and preventive services, as noted below with regard to *Bright Futures.* These services should be in every family's benefit package.

The ACA mandates coverage of well-child services as detailed in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition* (Copyright © 2010 American Academy of Pediatrics). Truly supporting the wide range of preventive services recommended through these guidelines is challenging. For instance, many screenings (such as developmental or maternal depression) are recommended by *Bright Futures*. These screenings require additional time and resources from pediatric providers, however they are often not reimbursed as separate services and considered part of the basic well-child visit. ICAAP also strongly believes that all plans should pay for the *coordination* of the aforementioned health care services (often in the context of the medical home). Care coordination is a primary function of a high quality medical home, and is often not

reimbursed or reimbursed inadequately. Illinois has the opportunity to work with the provider community to identify additional services that are not appropriately covered but contribute to high quality or recommended care, and to negotiate with health plans to ensure that they are included.

Attached, for more information on recommended coverage, is the American Academy of Pediatrics' 2006 statement "Scope of Health Care Benefits for Children From Birth through Age 21," which provides more detail on recommended benefits and coverage. We look forward to providing more specifics on the unique pediatric needs and issues that should be included in *all* health insurance plans.

We believe that requiring consistent reporting among health plans participating in the Exchange will not only be useful to consumers in making informed choices, but will contribute to a roadmap to help drive public and private efforts to improve health care quality.

Structure and Governance

If Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why? If the Exchange is run by an executive director and/or a governing board, what should be the expertise of those appointed? How long should the terms be? Are there existing models to which the State should look?

The Illinois Chapter of the American Academy of Pediatrics (ICAAP) offers no strong recommendations regarding governance structures. We highlight, however, that our organization and other provider and consumer advocacy groups work increasingly well with our partners in Healthcare and Family Services, Human Services, and other state agencies. Those agencies have the expertise, authority, and sensitivity to work with insurers, consumers, Medicaid, human service programs, and a wide variety of other stakeholders as will be required. While locating the governance within the State, either in a newly-created or existing executive branch agency, will certainly pose challenges, that structure may be most appropriate for the reasons noted above. A quasi-governmental board or commission may be more challenging in terms of ensuring a fair, open and efficient appointment process and policing conflicts of interest. Structuring the Exchange as a nonprofit entity would add the burden of either developing the nonprofit, or establishing a competitive procurement process whereby existing organizations bid to run the Exchange as a nonprofit, potentially creating conflict among groups with diverse interests, who are already collaborating successfully with the more "neutral" state agencies.

On a related note, individuals with disabilities and chronic conditions, including families with children with special needs, often have unique health care situations impacting their need for benefits, enrollment challenges and questions, and more. ICAAP suggests that Illinois HBE planners should create and utilize an Advisory Group as a regular and integral resource to provide input to design considerations, get feedback on proposals and share

information with people with disabilities. This group should be diverse and include individuals with disabilities, family members and caregivers, and include representatives of all disability groups – sensory, physical, mental and cognitive. The Advisory Group must have real ability to influence decisions.

The External Market and Addressing Adverse Selection

ICAAP offers the following general comments in response to many of the questions posed by the Council regarding this topic.

The history of insurance pools has shown us that one of the greatest threats facing Exchanges is adverse selection. ICAAP believes that severe consequences will ensue if an Exchange becomes, in essence, a high-risk pool, in that the Exchange will become unattractive to insurers while coverage through the Exchange will become unaffordable to individuals and to employers.

In order to minimize adverse selection, Exchanges could require insurers to offer the same plans inside and outside the Exchange. Illinois should develop and enforce market rules that are the same inside and out of the Exchange, so that carriers have little incentive to decline to participate. At minimum, the Exchange should be required to accept all eligible plans.

If Illinois chooses to institute a more selective or competitive process to determine which plans can be offered in the Exchange, the State should require insurers outside the Exchange to offer products in the same coverage levels, as required for health insurers participating in the Exchange. Exchanges should also be given the authority to establish bidding or other processes to regulate the amount and quality of participating plans.

Eligibility Determination

ICAAP offers the following general comments in response to many of the questions posed by the Council regarding this topic.

It is essential that Illinois create a well-coordinated, "no wrong door" access program for individuals and families to enroll in HBE programs. This program should take into account different geographic and socioeconomic situations, incorporate feedback from families and community stakeholders, and build on existing systems whenever possible.

- Enrollment periods should be sufficient to allow all families/consumers to learn sufficiently about their options and make decisions about participating, particularly upon initial enrollment.
- Online and telephonic enrollment options are insufficient, because low-income and other underserved communities disproportionately lack access to these options. In-person enrollment options must be made available.

- Illinois should also offer additional avenues for people to apply: by mail, through existing Medicaid or other Human Service enrollment structures, through kiosks in central locations (eg, schools or hospitals), through mobile units in rural communities, and by training assistors in community-based organizations, not unlike previous efforts to establish KidCare/All Kids Application Agents.
- The Illinois HBE should develop simple and efficient procedures for individuals and families to report changes of circumstances at the time of enrollment and during the rest of the year. When a family's eligibility changes, the family should be automatically enrolled (with consent) in the appropriate program or subsidy level without being required to submit further information. Families should be clearly notified about how the change will affect them (ie, change in premiums, cost-sharing, provider networks, and covered benefits).
- Linkages to other public programs, such as those of the Illinois Department of Human Services, are critical connectors. As much as possible, linkages with these other public programs should be automatic. For example, when a parent applies for unemployment benefits, the system should trigger a review of their family's eligibility for subsidies or public programs. When a child enrolls in Free School Lunch or Supplemental Nutrition Assistance Programs, or other income-related programs, Illinois should create automatic or expedited routes to coverage.

When enrollees move between public and private coverage, how should Illinois maintain continuity of health care -- in plan coverage and in availability of providers, e.g. primary care physician?

A strong, electronic Health Information Exchange (HIE) – currently under development in Illinois – that combines information from public programs like Medicaid and those in the private sector and the developing HBE will be critical in terms of sharing patient and provider data seamlessly across systems, including when plans or providers change. When enrollees move between public and private coverage, this system will help Illinois maintain continuity of health care in plan coverage and in availability of providers.

What will maximize coordination between Medicaid as a public payer and insurance companies as private payers offering health insurance on the Exchange in their provider networks, primary care physicians ("medical homes"), quality standards and other items?

The creation of an HBE will give Illinois the opportunity to move from a volume-based to a value-based health care system by putting in place measures to better reward the provision of primary care services. Exchanges represent an opportunity to make an investment in primary care; to pay more and differently for primary care services by moving away from fee-for-service to a system that rewards care coordination, improvement in outcomes, and value.

The Illinois Medicaid program has increased its focus on quality and increased provider satisfaction by tying incentive programs to quality metrics. These and similar pay for

performance programs exist in many health plans and have shown to improve care while directing payment to deserving providers. However, they are often unique to individual insurers or plans and not well coordinated, and require substantial and sometimes duplicative efforts to comply at the practice or clinic level.

Establishment of new child health measures and their promotion by the Centers for Medicare and Medicaid Services (CMS) offers new guidance on key measures and opportunity to experiment with strategies to improve them. As one of the states in receipt of a 2010-2015 Child Health Program Reauthorization Act (CHIPRA) Quality Demonstration Grant, Illinois will be working with these measures on many fronts: reporting, quality improvement for health care providers, and integration into Medicaid policy and programs. The establishment of the HBEs offers an opportunity to work with private payer to coordinate reporting on measures at the state level and at the practice level. Providers could more easily understand their patient needs and take actions to improve care when presented with a complete picture of their patients' needs and services, rather than by piecing it together based on insurance plan. Quality improvement efforts and related incentives that cut across public and private plans and therefore impact more patients and providers are likely to be very successful, and health care providers will be better able to participate.

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POLICY STATEMENT

Scope of Health Care Benefits for Children From Birth Through Age 21

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of All Children

Committee on Child Health Financing

ABSTRACT

The optimal health of children can best be achieved by providing access to comprehensive health care benefits. This policy statement outlines and defines the recommended set of health insurance benefits for children through age 21. These services encompass medical care, critical care, pediatric surgical care, behavioral health services, specialized services for children with special health care needs, and oral health. It replaces the 1997 statement, "Scope of Health Care Benefits for Newborns, Infants, Children, Adolescents, and Young Adults Through Age 21 Years."

All infants, children, adolescents, and young adults through 21 years of age must have access to comprehensive health care benefits that will ensure their optimal health and well-being. These benefits should be available through Medicaid, the State Children's Health Insurance Program (SCHIP), and private health insurance plans. Some of these benefits should also be available through the educational and public health systems for children with special needs and for children who are uninsured or have inadequate coverage.

Health care benefits for children and adolescents should begin with the full array of services recommended by the American Academy of Pediatrics (AAP). They should also reflect changes in treatment modalities and new technologies and should be evidence-based. Recognizing the importance of scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. If sufficient scientific evidence for an intervention for children is not available, professional standards of care for children must be considered. If professional standards of care for children do not exist or are outdated or contradictory, decisions about existing interventions must be based on consensus pediatric expert opinion (according to the AAP working definition in "Model Contractual Language for Medical Necessity for Children"[1]). Benefits should also be of high quality and should be delivered in an efficient manner by appropriately trained pediatric professionals including primary care pediatricians, pediatric medical subspecialists, and pediatric surgical specialists. These services should be delivered in a comprehensive medical home, the setting for primary care delivered or directed by well-trained physicians who are known to the child and family, who have developed a partnership of mutual responsibility and trust with them, and who provide accessible, continuous, coordinated, and comprehensive care.[2] Services provided in other settings should be coordinated through the child's medical home. These services should include but are not limited to the following.

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Key Words
health care benefits, insurance, infants, children, adolescents

Abbreviation
AAP—American Academy of Pediatrics

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275).

MEDICAL CARE

1. Medical care including (*a*) health supervision with preventive care (including immunizations, hearing and vision screening, developmental surveillance, and anticipatory guidance) according to the AAP "Recommendations for Preventive Pediatric Health Care,"[3] the most current version of the "Recommended Childhood and Adolescent Immunization Schedule,"[4] *Guidelines for Health Supervision III*,[5] and *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*[6] and (*b*) diagnosis, treatment, and educational counseling of children with acute and chronic conditions, including developmental delays and disabilities, behavioral and emotional problems, and learning disorders
2. Pediatric medical subspecialty services
3. Family planning and reproductive health services
4. Pregnancy services including (*a*) genetic counseling and related services as needed, (*b*) prenatal care, (*c*) prenatal consultation with a pediatrician, (*d*) perinatal case management, (*e*) care of all complications, (*f*) counseling and services for all pregnancy and fetal management options, and (*g*) care for the pregnancy of a covered dependent of a policyholder; prenatal care should include evaluation of psychologic risk factors
5. Care of all newborn infants, including (*a*) attendance and management at high-risk deliveries or those mandated by hospital regulations, (*b*) health supervision, (*c*) treatment of congenital anomalies and other medical and surgical conditions, (*d*) newborn intensive care services, (*e*) newborn hearing screening,[7] (*f*) newborn screening for metabolic and genetic disorders, (*g*) a follow-up visit in the child's home or in the physician's office within 48 hours of discharge when indicated by the infant's physician, (*h*) lactation counseling to increase successful breastfeeding initiation and duration, and (*i*) a reasonable pediatric length of stay to allow for identification of early problems and to ensure that the family is able and prepared to care for the infant at home if the mother has to remain hospitalized because of complications[8]
6. Vision services including screening, examinations, corrective lenses, and access to pediatric ophthalmologists for diagnostic and therapeutic services
7. Audiology services including screening, evaluations, hearing aids, cochlear implants, and recommended therapy
8. Physician-directed, accurate pediatric medical information by telephone, telemedicine, e-mail, and other Internet services for established patients related to pediatric care compliant with regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA [Pub L No. 104-191])
9. Laboratory and pathology services
10. Screening for metabolic and genetic disorders
11. Diagnostic and therapeutic radiology services, including age-appropriate sedation as needed
12. Coverage for prescription drugs determined by pediatric standards of care and not limited to labeled indications only[9]

CRITICAL CARE

13. Emergency medical and trauma care services specifically for children, including while traveling outside of the coverage network area
14. Pediatric inpatient hospital and critical care services
15. Emergent and nonemergent transfer/transport to a hospital or health facility, between health facilities, and between home and health facilities when indicated

PEDIATRIC SURGICAL CARE

16. Pediatric surgical care including comprehensive repair of congenital anatomic malformations
17. Pediatric surgical subspecialty services
18. Anesthesia services including monitored anesthesia care and appropriate pain management for acute and chronic pain management

BEHAVIORAL HEALTH SERVICES

19. Mental health services including (*a*) individual, group, and family therapy, (*b*) psychoeducational testing, (*c*) evaluation, (*d*) crisis management, (*e*) inpatient and day treatment, (*f*) residential care, and (*g*) pharmacotherapy; this should also include the following services: the evaluation and treatment of attention-deficit/hyperactivity disorder and other related behavioral disorders and treatment of eating disorders, learning disabilities, and related disorders[10,11]
20. Services for substance use disorders, including (*a*) screening and early intervention, (*b*) individual, group, and family therapy, (*c*) psychological testing, (*d*) crisis management, (*e*) inpatient and outpatient treatment, and (*f*) residential care
21. Comprehensive medical and psychologic evaluation and treatment for suspected child physical, emotional, and sexual abuse and neglect in both inpatient and outpatient settings

SPECIALIZED SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

22. Care coordination in the pediatric medical home and comprehensive case management from other community agencies and insurers[12]
23. Intermediate or skilled nursing facility care in residential and rehabilitation settings
24. Physical, occupational, speech (including speech generation), and respiratory therapy for rehabilitation and habilitation provided in medical centers, private/public-sector offices, schools, residential settings, and the home
25. Home health care services including but not limited to physician supervision of care, therapies, private-duty nursing, and home health aides[13]
26. Nutritional evaluation and counseling services by pediatricians, dietitians, nutritionists, and other therapists for eating disorders (including primary obesity, anorexia, and bulimia) and specific nutritional deficiencies
27. Special diets, special infant formulas, nutritional supplements, and delivery (feeding) devices for nutritional support and disease-specific metabolic needs[14]
28. Rental or purchase, maintenance, and service of durable medical equipment (see Appendix)
29. Disposable medical equipment (see Appendix)
30. Respite services for caregivers of children with special health care needs
31. Palliative and hospice care for children with terminal illnesses

PEDIATRIC ORAL HEALTH

32. Preventive and restorative pediatric dental care including fluoride varnish, sealants, and oral surgery, including moderate sedation and general anesthesia
33. Functional orthodontia

APPENDIX

Examples of Durable Medical Equipment Required in Pediatrics

1. Equipment necessary to administer aerosolized medications and monitor their effects (nebulizer, spacers for inhalers, peak flow meters)
2. Glucometers, insulin pumps
3. Breast pumps
4. Prostheses/braces
5. Electrical and other types of ventilators
6. Cardiorespiratory monitors
7. Oxygen concentrators
8. Pulse oximeters
9. Wheelchairs
10. Hearing aids

Examples of Disposable Medical Equipment

1. Diapers for physically compromised patients
2. Urine catheters
3. Feeding supplies (tubing, pumps, etc)
4. Intravenous line tubing and intravenous catheters
5. Ostomy supplies
6. Test strips, lancets, and other diabetic supplies

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